# Ethical Theories and Perspectives on End-of-Life Decisions

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**This paper approaches several different ethical theories to see how they interact with the issue of withdrawing and withholding life-sustaining care. After the theories of Utilitarianism, Kantian and Prima Facie Deontology, Virtue Ethics, and Evolutionary Ethics are explored at length, Deontological theories are proven to be the best decision-making guide from the perspective of both patients and those in policy-making positions. When used together, Kantian and Prima Facie Deontology offer the overall best combination of ethical instruction and personal freedom.**

When it comes to the withholding and withdrawing of life-sustaining care, both patients and policy makers are required to make tough ethical decisions. The theories of Utilitarianism, Kantian and Prima Facie Deontology, Virtue Ethics, and Evolutionary Ethics all attempt to offer ethical explanations and possibly guidance in decision making for situations such as this. However, deontological theories offer the best guide for both patients and policy makers because they allow for maximum freedom in personal medical decisions and protection for all members of society, including the disadvantaged.

## Ethical Theories Explained

Before diving into the decision making processes of patients and policy makers, it is essential to have a firm grasp on the different ethical theories that could be used to make decisions about withholding and withdrawing life-sustaining care. First, Consequentialist theories conclude that the rightness or wrongness of an action is determined by the goodness or badness of the consequences resulting from the action.[1] Therefore, when making a decision, a person must be able to list all the possible courses of action and all the possible consequences of each course, if taken. Utilitarianism is one theory that falls under the Consequentialist umbrella. One type, Act Utilitarianism, claims that a person should act in the way that produces the greatest amount of good over evil, and should consider everyone that would be affected by the action.[2] In other words, the ethically "correct" action is the one that causes the most pleasure and the least pain for the greatest amount of people. On the other hand, Rule Utilitarianism claims that a person should act according to the rule that, when generally followed, would produce the greatest amount of good over evil when considering everyone that would be affected by the rule.[3] This theory demands that all possible courses of action be considered based on the consequences of making that action into a rule that all members of society must follow. While Utilitarian theories do provide a guide for decision-making that allows the agent to consider the broad implications of their actions, they do not allow for special considerations of other things. For example, personal relationships are not given extra weight when considering the outcome of the action on others, and justice is not defined as fairness to all. These theories require that everyone's interests be weighted the same,

[1] Brand-Ballard, 2011
[2] ibid.
[3] ibid.

regardless of their relationship to the agent, which also makes it possible to sacrifice one small group of people or interests for the greater good of the majority. Furthermore, Utilitarian theories involve extensive and logical calculations before an action can be decided upon, which is not conducive to emotional or time-sensitive situations. Finally, these theories can produce an action that is morally right in one set of circumstances, but not in another. While this might be acceptable to individuals making their own personal decisions, it is not ideal for those, such as policy makers, that must set ethical guidelines for large groups.

In contrast to Consequentialist theories, Deontological theories do not determine the rightness or wrongness of an action based exclusively on its consequences. In Kantian deontology, a person is expected to act in accordance with the "categorical imperative," which stets two guidelines: an action should always be able to become a universal law, and an action should never use another person as a means to an end.[4] While the first part of the categorical imperative is similar to Rule Utilitarianism, the second part recognizes that humans have an inherent dignity that warrants respect. From this flows the idea that there are some "perfect duties" that can never be broken, because to break them would be to deny a person their due respect, or treat them as a means to an end rather than an end in themselves. While this theory provides very clear moral guidance, it can also be strict and inflexible in situations where there may be a conflict of interests. For example, in the well-known thought experiment where a murderer is asking for the location of a friend, and the agent must decide whether to lie (and save the friend) or tell the truth (and lead to the friend's death), Kant would reply that lying uses the murderer as a means to meet the end of keeping the friend alive, and as a human being the murderer must not be used as a means to any end. Prima Facie deontology, however, attempts to solve the conflict of duties that is apparent in the Kantian theory. While it still imposes unbreakable duties, such as fidelity, beneficence, and justice, it also allows the agent to give special consideration to personal relationships.[5] When a relationship comes into conflict with a duty, like in the thought experiment above, it would be acceptable for the agent to shirk the duty in light of the relationship. However, the Prima Facie theory does not offer guidance on how to decide which duties and relationships are more important than others, or when a situation becomes extreme enough to warrant the shirking of a perfect duty.

While Consequentialist and Deontological theories focus on the morality of individual actions, Virtue Ethics focuses on the morality of individual people. This theory deems certain character traits, such as truthfulness, courage, and compassion, more desirable and worthy of fostering than others.[6] It also takes into consideration the motivation behind actions, which stems from the contention that the cultivation of enduring traits and attitudes is more effective than the prescription of an action-guide. However, Virtue Ethics does not provide concrete guidance when the agent is faced with a tough decision. To use the above thought experiment again, the agent would not know whether the character trait of truthfulness (to the murderer) or compassion (to the friend) should take precedence. For this reason, it has been argued that Virtue Ethics should be used as a supplement to action-based ethics.

Finally, and much different from all of the above, the theory of Evolutionary

[4] ibid.
[5] ibid.
[6] ibid.

Ethics contends that having a moral sense can be biologically explained as a product of natural selection.[7] In other words, morality is an adaptation that increased the reproductive fitness of intelligent beings such as humans. This would mean that moral constructs and ethical debate is not a product of divine revelation or rational thought, but simply a product of evolution. However, this theory does not give an explanation of how moral "rightness" should be defined, or of the advantage that moral behavior offers in the context of evolution and natural selection. This theory attempts to explain the origin of ethical behavior rather than provide a basis for decision-making or action.

**Ethical Theories Applied to Patients**

Now that the theories of Utilitarianism, Kantian and Prima Facie Deontology, Virtue Ethics, and Evolutionary Ethics have been explored, their usefulness to patients and medical policy designers making decisions about withholding and withdrawing life-sustaining care may be examined. To begin this exploration, it is salient to note that there are typically two types of patients that consider denying or ending care that would otherwise keep them alive: terminal and non-terminal patients.[8] Terminal patients have a medical diagnosis, usually of disease, that will end their life. If they choose to abstain from medical intervention, the disease will take their life more quickly than it would have with intervention. If they have already started medical treatment for the disease, ceasing the treatment will also cause the disease to take their life more quickly than it would have with continued treatment. Non-terminal patients, however, have a medical diagnosis of a disease or significant injury that will not end their life, but may require that they live differently than they are accustomed to. In these cases, the withholding or withdrawing of medical intervention, rather than the disease or injury, ends their life.[9] Complicating factors in both of these scenarios are the recognition by the AMA of intravenous hydration and nutrition as medical care that a patient can choose to withhold or withdraw, and the lack of recognition of a moral difference between withholding and withdrawing care.[10] At this point in the discussion, it is important to emphasize that when either type of patient chooses to withhold or withdraw life-sustaining care, they are choosing to hasten their death.

There are a multitude of reasons that a patient would choose to hasten their death, but ultimately those reasons boil down to the way they want to live their remaining life.[11] Terminal patients may not want to spend the rest of their time in a hospital setting or experiencing one invasive procedure after another. Non-terminal patients may not want to live with the significant restrictions on their activity that their diagnosis requires, especially when they can remember living a life of freedom. At this point, patients must make a decision about the way they want to live, and the way they want to die. The ethical theories discussed earlier can help guide this decision-making process. Most patients will consider the consequences to others of their decision to withhold or withdraw life-sustaining care, but the Consequentialist theory of Utilitarianism puts too much weight on the impact to others. For example, if the patient's family were not supportive of their decision to withhold or withdraw care, regardless of how compelling their reasons for the decision, they would be morally obligated

[7] Schroeder
[8] Michel, 1995
[9] ibid.
[10] Council on Ethical and Judicial Affairs, American Medical Association, 1992
[11] Griffith, 2015

not to do it because it would cause grief or discomfort to the majority of the people involved. Virtue Ethics and Evolutionary Ethics do not offer formulas or even guides to decision-making, especially in circumstances where there is not a decision that is clearly more "ethical" than the other. Therefore, Deontological theories provide the most guidance in this area. Kantian ethics requires the patient as well as others to respect the patient's dignity as a human being, though it may take issue with the patient choosing to die because the patient is using their own person as a means to an end. Prima Facie ethics allows the patient to consider the opinions of those they are in close relationship with when making their decision, but does not allow the opinions of others to eclipse what the patient ultimately desires and feels is right for them. Incidentally, this falls in line with what medical professionals and social workers in medical settings are trained to keep in mind when dealing with patients making end-of-life decisions.[12,13] Thus, deontological theories, when used in combination, allow for the maximum amount of personal freedom to the patient while still allowing the patient to consider the perspectives of loved ones.

**Ethical Theories Applied to Policy**

Currently in the United States, as well as worldwide, there is not a consensus of policy concerning who is eligible to refuse life-sustaining care and who is not, or what exactly constitutes as care that a patient can refuse. As mentioned earlier, the AMA contends that intravenous hydration and nutrition are medical treatments that can be rejected by a patient and that there is no moral difference between the withholding and withdrawing of life-sustaining care. However, not all countries agree with these conclusions.[14] This ongoing ethical debate between cultures and nations has created a climate in all countries where patients that should be eligible to refuse care are unable, and patients that should not be eligible, are able.[15] Therefore, policy makers of all nations should consider the ethical theories above and create a cohesive policy on the subject. The United States, though, is especially in need of a clear and cohesive policy because there are a multitude of cultures present in the American society that draw from the opinions and laws of their mother country. However, legislators and judges tasked with creating policy about the withdrawing and withholding of life-sustaining care have a slightly different and conflicting set of circumstances to consider when making decisions. They must attempt to reconcile allowing individuals to make their own medical decisions with protecting society while also guiding it on the correct moral path. For example, they must ensure that patients are able to act autonomously when making the decision to refuse or discontinue care. An "autonomous" decision is one that is free from both external and internal restraints.[16] Examples of external restraints are pressure from family members/medical professionals and financial burdens, while examples of internal restraints are lack of information about a person's condition/treatment options and mental illness. Therefore, the policy created should encourage physicians to disclose full information about a patient's diagnosis, prognosis, and treatment options in a way that the patient can clearly understand, as well as ensure the patient is acting on their own accord and in freedom from external duress.

[12] Griffith, 2015
[13] McLuckey, 2016
[14] Argent, 2014
[15] Downie, 2016
[16] Brand-Ballard, 2011

In order to create such a policy, legislators might turn to the ethical theories mentioned above for guidance. Utilitarianism is attractive when making decisions that affect large groups of people because it gives the opinions of all people the same weight in consideration, and then chooses the option that pleases most people. However, this same factor of Utilitarianism allows for a small group of people to become marginalized for the sake of the larger group. Since patients considering withholding or withdrawing life-sustaining care make up a small portion of the population, this theory could lead to their mistreatment by legislators. Rule Utilitarianism at least allows for the consideration of the effect the policy would have on the morality or ethics of the population as a whole, but ultimately also succumbs to the will of the majority. Again, Virtue Ethics and Evolutionary Ethics do not provide a concrete decision-making guide for specific situations. Virtue Ethics does encourage the trait of compassion, which might aid policy makers wanting to set an example for the rest of society on the treatment of struggling patients, but does not point to any framework for the policy itself. Deontological theories, once more, prove to be the most helpful in guiding the decision-making process on the withholding and withdrawal of care. Kantian ethics, especially, allows legislators to recognize the dignity of the individual and their right to make personal decisions about their medical care, while still considering the affect the policy would have on society as a whole. Again, Kantian ethics might take issue with the idea of a person choosing to end their life, but a combination of Kantian and Prima Facie Deontology allows for the protection of individual freedom in decision-making. Remember, though, that the categorical imperative still requires that an action or policy have the ability to be made into a universal rule capable of being followed by all members of society. In order for this to be possible, legislators would have to create a policy that clearly lays out the qualifications and guidelines for choosing to withhold or withdraw medical care. Thus, deontological theories provide the best framework for policy makers in this particular realm.

A special condition that policy makers also must consider is that of mental or physical disability, which, as mentioned above, is classified as an internal restraint of autonomy. Often, and understandably, patients considering withholding or withdrawing life-sustaining care are disturbed by their diagnosis- otherwise, they would not have reached the conclusion that dying is better than continuing to live. Physicians, therefore, should make sure that the patient has reached this conclusion out of rational and healthy thought rather than under the influence of depression. This is especially true for non-terminal patients with physical or mental disabilities, who often experience depression stemming from their newfound physical restrictions and the social attitude toward, and lack of accommodations and opportunities for, the disabled. As Michel (1995) points out in his article, if an able-bodied and able-minded person expresses a wish to die, it is assumed the person is depressed and the wish to die is coming from their altered mental state. But, when a disabled person expresses the wish to die, their requests are more often granted without an in-depth examination for depression. Policy makers, then, need to pay special attention to societal attitudes toward the disabled and work to foster an environment where they are treated with the same respect and dignity as an able-bodied person. While this includes the incorporation of more accommodations and opportunities for the disabled in mainstream society, it begins with the requirement of depression

screening for both terminal and non-terminal patients requesting to withhold or withdraw life-sustaining care. In this way, the most vulnerable of citizens would be protected from both external and internal pressures that could lead them to the decision to end their life. The deontological theories of ethics support this since they allow for personal freedom in decision-making, but keep the policy from being taken advantage of by people wishing to use themselves as means to an end.

**Conclusion**

When examining the ethical theories of Utilitarianism, Kantian and Prima Facie Deontology, Virtue Ethics, and Evolutionary Ethics, deontological theories offer the best guide for making decisions about the withholding or withdrawal of life-sustaining care in both terminal and non-terminal patients. Utilitarian theories do not allow for the patient's wishes or the opinions of the patient's friends and family to weigh more heavily than anyone else's, and can allow for small groups to be marginalized for the good of the whole – neither of which are ideal in circumstances where personal medical decisions are being made. Virtue Ethics and Evolutionary Ethics do not provide a solid outline for decision-making, rendering them inadequate in this situation. So, both medical policy makers and patients can rely on deontological theories to provide both the maximum amount of personal freedom and protection for society at large.

Patients are able to make decisions based mainly on their own values and desires, but are also able to account for the effect their decision will have on those around them. Policy makers are able to allow for this personal freedom in decision-making, while still protecting the morality of society as a whole. Using deontological theories, policy makers can also assure that the policy does not put disabled people at a higher risk than other people, and that the policy is not used too openly or too sparingly. Essentially, using a mixture of Kantian and Prima Facie deontology allows patients as well as policy makers to have the best of both, or all, worlds when drawing conclusions about the withholding and withdrawing of life-sustaining care.

**Literature Cited**

Argent, A., Du, B., Feldman, C., Groeneveld, A.B.J., Guidet, B., Hartog, C.S. … & Sprung, C.L. (2014). The Durban World Congress Ethics Round Table Conference Report: I. Differences between withholding and withdrawing life-sustaining treatments.

Brand-Ballard, J., DeGrazia, D., & Mappes, T. A. (2011). *Biomedical ethics* (7th ed). New York, NY: McGraw-Hill Higher Education.

Council on Ethical and Judicial Affairs, American Medical Association. (1992). Withholding and withdrawing life-sustaining treatment. *Journal of the American Medical Association,* **267**(16), 2229-2233

Downie, J. (2016). And miles to go before I sleep: The future of end-of-life law and policy in Canada. *Dalhousie Law Journal*, **39**(2), 413-430.

Griffith, R. (2015). Withholding or withdrawing life-sustaining treatment. *British Journal of Cardiac Nursing*, **10**(6), 304-305.

Lowenstein, B., & Powell, T. (1996). Refusing life-sustaining treatment after catastrophic injury: Ethical implications. *Journal of Law, Medicine, and Ethics,* **24**, 54-61.

McLuckey, L. & Therivel, J. (2016). End-of-life care and decision making. *Social Work Reference Guide.*

Michel, V. (1995). Suicide by persons with disabilities disguised as the refusal of life-sustaining treatment. *HEC Forum*, **7**(2-3), 122-131.

Schroeder, D. (n.d.). Evolutionary ethics. In *Internet Encyclopedia of Philosophy*. Retrieved from http://www.iep.utm.edu/evol-eth/